HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in Health Policy

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RFP CALENDAR

HMA News

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THIS WEEK

IN FOCUS

MEDICARE AND MEDICAID FLEXIBILITIES DURING PUBLIC HEALTH EMERGENCIES

This week, our *In Focus* comes from HMA Vice President Kathleen Nolan and Managing Principal Jon Blum. On March 13, 2020, President Trump declared a national emergency due to the rapid spread of COVID-19 virus. This

declaration provides Health and Human Services (HHS) and the Centers of Medicare and Medicaid Services (CMS) new abilities to waive Medicare and Medicaid regulatory requirements to help health care providers, health plans and other stakeholders respond to immediate needs of their patients and communities. In the past, HHS and CMS have solicited requests for relief needs from states, local providers and trade associations, among other stakeholders. Health care providers, health plans and others should continue to monitor policy announcements from HHS and CMS and work with their states and trade associations to identify potential areas of need for requested regulatory relief.

This brief summarizes the legislative authorities for how Medicare and Medicaid are able to respond during national emergencies and already announced waivers to provide additional flexibilities.

Federal Section 1135 Waiver Flexibility

Section 1135 of the Social Security Act permits CMS and authorizes the HHS Secretary to take certain regulatory actions when both the President declares a national disaster or emergency and the HHS Secretary declares a public health emergency. As of March 13, both conditions were met to grant this authority. The HHS Secretary— through CMS—can waive statutory and regulatory provisions for health care providers, including:[i]

- Conditions of participation or other certification requirements.
- Program participation.
- Preapproval requirements.
- Requirements that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have equivalent licensing in another state (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-federal provider is authorized to provide services in the state without state licensure).
- Emergency Medical Treatment and Labor Act (EMTALA) sanctions for redirection of an individual to receive a medical screening examination in an alternative location pursuant to a state emergency preparedness plan (or in the case of a public health emergency involving pandemic infectious disease, a state pandemic preparedness plan) or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency. A waiver of EMTALA requirements is effective only if actions under the waiver do not discriminate on the basis of a patient's source of payment or ability to pay.
- Stark self-referral sanctions.
- Performance deadlines (may be adjusted but not waived).
- Limitations on payment to permit Medicare Advantage enrollees to use out of network providers in an emergency situation

Under this authority, CMS may also permit Medicare Administrative Contractors (MACs) to pay for Part C-covered services furnished to Medicare Advantage enrollees and subsequently seeking retroactive reimbursement from Medicare Advantage Organizations for those health care services.

[i] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers

Health care providers may need to submit requests to operate under the 1135 Waiver authority to the State Survey Agency or CMS Regional Office. These requests typically include a justification and expected duration for the request. Providers are also expected to keep records of services furnished to beneficiaries under waiver authority in order to ensure coverage and payment. CMS may also elect to implement certain waivers under the 1135 authority on a comprehensive basis rather than for individual providers when a determination has been made that all similarly situated providers in the emergency area need such a waiver or modification.

These waivers typically end after the termination of the emergency period, but HHS may extend them for an additional 60 days after the termination.

Announced 1135 Waivers

To date, CMS has announced the following waivers under 1135 authority.

- ***Expansion of Telehealth Coverage:***[ii] CMS will reimburse for office, hospital, and other visits furnished via telehealth in all areas of the country and in all settings, including in a patient's place of residence starting March 6, 2020, and for the duration of the emergency. The provider must use an interactive audio and video telecommunications system that permits real-time communication. These telehealth visits will be treated as in-person visits and reimbursed accordingly. The Medicare coinsurance and deductible still apply to these services, but HHS will allow providers to reduce or waive cost-sharing.

  Prior to this waiver, telehealth visits were only covered for beneficiaries in designated rural areas and leaving their home to receive care in a qualifying originating site (e.g., clinic, hospital, or certain other types of medical facilities). While the 1135 waiver authority requires an established relationship between patient and provider, CMS indicates the Agency will not audit claims for purposes of ensuring a relationship for the duration of the emergency. CMS also announced that the HHS Office for Civil Rights (OCR) will waive penalties for HIPAA violations against health care providers acting in good faith to serve patients through everyday communications technologies during the emergency.
- ***Skilled Nursing Facility (SNF) Eligibility, Coverage, and Resident Assessment Requirements:*** CMS waived the requirement for a 3-day prior hospitalization for coverage of a Medicare SNF stay. It authorizes renewed SNF coverage for certain beneficiaries who recently exhausted their SNF benefits. It also waived SNF resident assessment requirements to provide relief to SNFs on the timeframe for Minimum Data Set (MDS) assessments and transmission.
- ***Critical Access Hospital (CAH) Limits:*** CMS waived requirements that CAHs limit the number of inpatient beds to 25, and that average length of stay not exceed 96 hours.
- ***Housing Patients in Hospital Excluded Distinct Part Units – Inpatient Rehabilitation and Psychiatric Services*:** CMS will permit acute care hospitals to house acute care inpatients in excluded distinct part units (i.e., units typically designated for psychiatric services or rehabilitative services), where the distinct part unit's beds are appropriate for acute care inpatients. Hospitals using this flexibility must bill under the Inpatient

[ii] https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Prospective Payment System (IPPS) and to annotate the patient's medical record to note the patient is being treated in the excluded distinct part unit because of capacity issues related to the emergency.

- ***Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Replacement Policies:*** CMS announced that MACs may waive requirements for a face-to-face visit, a new physician's order, and new medical necessity documentation to replace DMEPOS that is lost, destroyed, irreparably damaged, or otherwise rendered unusable. DMEPOS suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are expected to keep supporting documentation.
- ***Care for Excluded Inpatient Rehabilitation and Psychiatric Unit Patients in Acute Care Units of Hospitals*:** CMS waived requirements to allow acute care hospitals with excluded distinct inpatient rehabilitation or psychiatric units to relocate inpatients from those excluded distinct units to an acute care unit. Hospitals must bill for these patients under the existing payment system (i.e., inpatient rehabilitation facility prospective payment system and inpatient psychiatric facility prospective payment system) and indicate in the medical record that the patient is being treated in the acute care unit as a result of the emergency.
- ***Long-Term Care Acute Hospital (LTCH) and Inpatient Rehabilitation Facility (IRF) Threshold Requirements:*** CMS waived threshold requirements for LTCHs and IRFs. LTCHs can exclude patient stays resulting from the emergency for purposes of calculating the facility's average length of stay. Under regular circumstances, LTCHs are required to have an average length of stay greater than 25 days. IRFs may exclude patients from the facility or unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements that 60 percent of the IRF's patients have one of 13 qualifying conditions.
- ***Home Health Agency (HHA) Relief*:** CMS waived requirements related to timeframes for HHA patient assessment (OASIS) transmission. MACs will also be able to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) (i.e., HHA prepayment based on anticipated overall payment) during emergencies.
- ***Provider State Licensure Requirements and Enrollment Flexibilities***: CMS announced multiple initiatives and flexibilities for provider state licensure and enrollment requirements, including:
  - Toll-free hotline for non-certified Part B suppliers, physicians and nonphysician practitioners to enroll and receive temporary Medicare billing privileges
  - Waiver of the following screening requirements: 1) application fee, 2) criminal background checks, 3) site visits
  - Postponing all revalidation actions
  - Allowing licensed providers to render services outside of their state of enrollment (this applies to Medicare and Medicaid)
  - Expediting any pending or new applications
- ***Medicare Appeals*:** MACs, Medicare Advantage plans and Part D plans must:
  - Allow extensions to file an appeal
  - Waive timeliness for requests for additional information to adjudicate the appeal

- Process the appeal even with incomplete Appointment of Representation forms but communicating only to the beneficiary
- Process requests for appeal that don't meet all required information elements by using information that is available
- Utilize all flexibilities available in the appeal process as if good cause requirements are satisfied

CMS has stated that states and territories seeking relief for Medicaid & CHIP requirements, including but not limited to those listed above, are encouraged to submit a Section 1135 waiver request directly to Jackie Glaze, CMS Acting Director, Medicaid & CHIP Operations Group Center for Medicaid & CHIP Services by e-mail (Jackie.Glaze@cms.hhs.gov) or letter.

Earlier this week, Florida became the first state to receive approval for a Section 1135 waiver in response to the COVID-19 national emergency. Flexibilities include: waiving prior authorization requirements to remove barriers to needed services, streamlining provider enrollment processes to ensure access to care for beneficiaries, allowing care to be provided in alternative settings in the event a facility is evacuated to an unlicensed facility, suspending certain nursing home screening requirements to provide administrative relief, and extending deadlines for appeals and state fair hearing requests.[iii]

State Medicaid And CHIP Programs Response Options

States may waive certain Medicaid and CHIP requirements using three broad authorities.

1. **General State Plan Flexibilities:**

State Medicaid and CHIP programs have the ability to reduce and eliminate barriers for screening and treatment during periods of emergency or disaster under a national or state emergency, including temporary changes to Medicaid to simplify enrollment and renewal processes, expanding presumptive eligibility to new providers and new populations, making the Medicaid agency a qualified entity for presumptive eligibility determinations, and ability to submit a State Plan Amendment to make adjustments to cost sharing for impacted individuals.[iv]

Use of these flexibilities may cover the entire state Medicaid population or specific to those impacted populations under State Plan authority. For example, on March 11, 2020, Pennsylvania took advantage of some of this flexibility, announcing that it would ensure coverage for testing and treatment of COVID-19, remove related prior authorization requirements, and require providers to treat individuals regardless of ability pay any associated copayments.[v] States with separate CHIP programs may submit a disaster relief state plan amendment that can be retroactive and allows for flexibilities similar to those available in Medicaid such as waivers of cost sharing and premiums, and extending the timeframe for renewals.

2. **Emergency Section 1115 Waivers**

[iii] https://www.medicaid.gov/state-resource-center/downloads/fl-section-1135-appvl.pdf

[iv] https://www.macpac.gov/wp-content/uploads/2018/03/Medicaids-Role-in-Disasters-and-Public-Health-Emergencies.pdf

[v] https://www.governor.pa.gov/newsroom/gov-wolf-medicaid-and-chip-recipients-covid-19-testing-and-treatment-resources-are-covered/

Emergency Section 1115 Waivers process allows for an expedited submission and approval timeline, without requiring either state or federal public comment periods where there is a disaster, public health emergency, or other sudden emergency that could not have been reasonably foreseen. These waivers were deployed to ensure coverage following September 11th, for individuals impacted by Hurricane Katrina, and to extend coverage to those impacted by the Flint water crisis.

Emergency Section 1115 Demonstrations have been used to extend coverage to target populations, simplify application processes, and grant temporary coverage based on member self-attestation without requiring documentation. In addition to simplified applications and expedited enrollments, Emergency Section 1115 Demonstrations permit extension of limited or full benefits to target populations, which may include individuals with income or resources beyond the existing state plan limits. The full spectrum of 1115 authority is available under the emergency option, which could include flexibility authorizations related to delivery system, reimbursement, applications and enrollment, as well as expanding eligibility. Pursing these waivers may have impacts on other non-Medicaid programs such as the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Marketplace eligibility.

3. 1915 (c) Waiver Appendix K

Waivers operating under 1915 (c) authority providing home and community-based services, may be modified with the submission of Appendix K during an emergency. CMS can approve this appendix retroactively, permitting states to establish an emergency hotline, provide case management and applicable personal care to be conducted telephonically or via other telehealth medium, increase the number of individuals covered under the waiver, modify provider requirements to increase access, and pay for HCBS services during short term hospital or institutional stays. States may also increase individual eligibility cost limits, modify services and limitations and permit payment to family caregivers under Appendix K. This appendix may also be used to address qualifying populations that may be in quarantine due to COVID-19.

CMS Activity And Guidance To Date

Prior to the President's declaration, CMS made the following announcements to assist health care communities respond to COVID-19:

Medicare Parts A & B

- ***New Billing Codes for COVID-19 Diagnostic Tests:***[vi] CMS announced the development of two new Healthcare Common Procedure Coding System (HCPCS) codes for healthcare providers to enable providers to bill for detection of COVID-19. HCPCS code U0001 can be used by providers and laboratories to bill for the Centers for Disease Control and Prevention's (CDC's) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel. HCPCS code U0002 allows laboratories and providers to bill for non-CDC COVID-19 diagnostic tests that are developed by laboratories and validated by the Food and Drug Administration (FDA). Claims for these codes will be accepted as of April 1, 2020 for dates of service on or after

[vi] https://www.cms.gov/newsroom/press-releases/public-health-news-alert-cms-develops-new-code-coronavirus-lab-test

February 4, 2020. CMS established payment rates for U0001 and U0002 at approximately $36 and $51, respectively.[vii] There is no beneficiary cost-sharing for these tests, as with other laboratory tests.

- ***Alternative Care Sites (ACSs)*:** A hospital may add a remote location that provides inpatient services, provided that the remote location satisfies the requirements to be "provider-based" to the hospital's main campus, in addition to the Hospital Conditions of Participation (CoPs). The hospital would be expected to file an amended Form CMS 855A (Medicare Enrollment Application) with its MAC.
- ***Hospital Payment in Event of Skilled Nursing Facility (SNF) Bed Shortages***: A physician may certify or recertify the need for continued hospitalization if the patient could receive proper treatment in a SNF, but no participating SNF bed is available. Under these circumstances, Medicare will pay the diagnostic related grouping (DRG) rate and any cost outliers until the Medicare patient can be moved to the appropriate facility.
- ***Separate Payments to Facilities for Controlling Infectious Disease*:** According to CMS, there are no separate payments for supplies for infection control, however, additional resources (e.g., supplies, staffing) for infection control may be made available from other local, state, or federal government agencies. Medicare typically doesn't allow payment for services that are paid for by another government entity, but CMS recently announced an exception for services furnished for purposes of controlling infectious diseases.
- ***Provider-Specific Infection Control Guidance:***[viii,ix,x] CMS issued detailed guidance to hospitals, nursing facilities, and hospice providers addressing patient triage and placement of/staffing for patients with known or suspected COVID-19 to limit transmission.

Medicare Advantage (MA) and Part D:[xi]

- ***Special Requirements During a Disaster or Emergency*:** CMS recently reminded MA plans that during a disaster or emergency, plans are obligated to: 1) cover Parts A/B and supplemental Part C services furnished by non-contracted Medicare facilities and provide the same cost-sharing for the enrollee as if the service had been furnished at a contracted facility, and 2) waive requirements for gatekeeper referrals where applicable.
- ***Permissible Part C Flexibilities:*** CMS announced it will add additional plan flexibilities to support efforts to diagnose, treat, and limit transmission of COVID-19. These include:
  - Waiving or reducing enrollee cost-sharing for COVID-19 laboratory tests
  - Expanding access to telehealth benefits, as well as waiving or reducing enrollee cost-sharing for these services
  - Waiving prior authorization requirements that would apply to tests or services related to COVID-19

[vii] https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf
[viii] https://www.cms.gov/files/document/qso-20-13-hospitalspdf.pdf-2
[ix] https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf
[x] https://www.cms.gov/files/document/qso-20-16-hospice.pdf
[xi] https://www.cms.gov/files/document/hpms-memo-covid-information-plans.pdf

- ***Permissible Part D flexibilities:*** Part D plans also have the ability to take certain actions during a disaster or emergency. These include:
  - Relaxing "refill-too-soon" edits
  - Reimbursing enrollees for prescription drugs purchased from out-of-network pharmacies
  - Relaxing plan-imposed policies that may discourage certain methods of delivery (i.e., home or mail delivery) for retail pharmacies that offer these services under these circumstances
- ***COVID-19 Vaccine Coverage*:** CMS announced that once a vaccine becomes available for COVID-19, Medicare will cover the vaccine under Part D. All Part D plans will be required to cover the vaccine

Medicaid and CHIP

FAQs for Medicaid and CHIP Agencies:[xii] Actions to address COVID-19 via Medicaid and CHIP will be initiated at the state level. To support state actions, CMS published guidance March 12, 2020, outlining authorities available and directing states to existing resources. This includes direction to the existing disaster response toolkit[xiii] and information on flexibilities available in an emergency under Section 1115, Section 1135, and 1915(k) waivers as well as Medicaid and CHIP State Plan flexibilities.

Commercial Insurance

For large group, small group and individual markets regulated by states, coverage for COVID 19 testing and treatment can be mandated by state insurance commissioners and plans can be required to provide coverage without applying plan cost sharing. As of March 11, this approach had been taken by Oregon, California, New York, Georgia, Maryland, and Washington. Self-insured plans offered by larger employers would not be impacted by state directives; employers may reach out to their third-party administrators to define coverage and costsharing for COVID-19. However, several health insurance plans stated that testing and treatment is covered and that cost-sharing will not be applied.

High-Deductible Plans In The Commercial Market

In coordination with CMS direction that COVID-19 testing and treatment is covered under essential health benefits required in individual and small group plans[xiv], the IRS published guidance allowing these plans to cover COVID-19 testing and treatment without applying cost-sharing, even if the covered individual had not yet met their deductible.[xv]

[xii] https://www.medicaid.gov/state-resource-center/downloads/covd-19-faqs-20200312.pdf

[xiii] https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html

[xiv] https://www.cms.gov/files/document/03052020-individual-small-market-covid-19-fact-sheet.pdf

[xv] https://www.irs.gov/pub/irs-drop/n-20-15.pdf

HMA Medicaid Roundup

Florida

Florida Receives Federal Approval for 1135 Medicaid Waiver to Help Address COVID-19 . The Centers for Medicare & Medicaid Services (CMS) announced on March 17, 2020, that it has approved Florida's Section 1135 Medicaid waiver request, giving the state greater flexibility to respond to COVID-19. Flexibilities include removing barriers to needed services, streamlining provider enrollment processes, allowing care to be provided in alternative settings, suspending certain nursing home screening requirements, and extending deadlines for appeals and state fair hearing requests. Florida was the first state to apply for the waiver. Read More

Lawmakers Agree on Budget Without Cuts To Medicaid Supplemental Payments. *WUSF/News Service of Florida* reported on March 15, 2020, that lawmakers in Florida agreed to a $92 billion budget, without making cuts to $64 million in supplemental Medicaid funding. The budget allocates $25 million to help prevent the spread of COVID-19 and anticipates a likely downturn in revenues stemming from the economic impact of the virus. Read More

Florida Enacts Law Allowing Independent Practices for Nurses. *The Associated Press* reported on March 11, 2020, that Florida Governor Ron DeSantis signed a bill allowing advanced practice registered nurses to provide certain types of care and establish practices without protocols or agreements with supervising physicians. The bill was a priority for House Speaker Jose Oliva (R-Miami). Separately, DeSantis also signed a bill that would allow pharmacists who enter into agreements with doctors to treat chronic conditions and ailments. Both laws take effect July 1. Read More

Illinois

Illinois Medicaid Plan is Questioned by CMS Over Unpaid Claims. *Becker's Hospital Review* reported on March 16, 2020, that the Centers for Medicare & Medicaid Services (CMS) is seeking an explanation from CountyCare, an Illinois Medicaid plan owned by Cook County Health and Hospital System, for $350 million in unpaid claims. CountyCare chief executive James Kiamos said late payments from the state and the county are the reason for the unpaid claims. Read More

Illinois Bill Would Further Delay Transition to Managed Care for Foster Children. *Patch* reported on March 12, 2020, that Illinois state Representative Tom Weber (R-Lake Villa) sponsored a bill to further delay the transition to managed care for foster children. The bill, co-sponsored by Jaime Andrade (D-Chicago), would postpone the transition from April 1, 2020, to at least a year from now. Weber cites the lack of a provider network as the main obstacle to the transition. The transition to the managed care program, called YouthCare, would impact 36,000 foster children. IlliniCare Health (Centene) was awarded the contract. Read More

Kentucky

House Approves Bill to Establish Single PBM, Formulary for Medicaid Managed Care. *The Courier Journal* reported on March 13, 2020, that the Kentucky House passed a bill that would require the state Medicaid agency to hire a single pharmacy benefit manager (PBM) to process all prescription drug claims for the state's five contracted Medicaid managed care organizations (MCOs). The bill would also establish a single formulary to be used by each of the five MCOs. The bill, which passed the House with minor changes from a Senate version, now returns to the Senate for final approval. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Governor Requests Federal Government Re-open ACA Enrollment in Response to COVID-19. *Insider NJ* reported on March 15, 2020, that New Jersey Governor Phil Murphy asked federal regulators to open a Special Enrollment Period in New Jersey to allow residents who are uninsured or underinsured to enroll in an Exchange plans. The request, which was prompted by the COVID-19 crisis, was submitted in a letter to the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS). Read More

New York

New York Medicaid Redesign Team to Issue Recommendations to Lawmakers. *Politico* reported on March 18, 2020, that the New York Medicaid Redesign Team II (MRT II) is expected to recommend a 1.875 percent across-the-board cut in the next two fiscal years, a redefinition of the Medicaid global cap, and a series of changes to long-term care to manage the state's $4 billion Medicaid budget shortfall. Other recommendations include a 60-month look-back period for home- and community-based eligibility, cutting nursing home capital funding, capping statewide managed long-term care enrollment growth, and delaying implementation of the expansion of Community First Choice Option services. The recommendations total $2.5 billion in savings in fiscal 2021 and more than $3 billion in fiscal 2022. Read More

New York Issues Guidance on Authorization of Community-Based Long Term Services and Supports. On March 18, 2020, the New York Department of Health released guidance on authorization of community-based Long Term Services and Supports (LTSS) in response to the challenges posed by COVID-19. The state will temporarily allow telephonic completion of the Community Health Assessment (CHA) for LTSS services. It has also suspended the need for periodic reassessments of CHAs, as well as the six-month in-person care management home visit requirement. In the Consumer Directed Personal Assistance program the state is suspending the annual renewal of the health assessment and immunization updates for all personal assistants currently providing care. It does not suspend those requirements for new personal assistants, and therefore, does not address the need for additional personal assistants should current providers become unable to work due to COVID-19 concerns.

New York Community Hospital, Maimonides to Explore Further Relationship. *Crain's New York* reported on March 16, 2020, that Maimonides Medical Center and New York Community Hospital have signed a letter of intent to explore a further relationship, including a possible merger. New York Community Hospital, one of Brooklyn's remaining independent hospitals with 134 beds, has been in a clinical collaboration with Maimonides, Brooklyn's largest hospital, since 2018. Read More

Ohio

Ohio Releases Medicaid Fiscal Intermediary RFP. Ohio released on March 17, 2020, a request for proposals for an Ohio Medicaid Enterprise System (OMES) Fiscal Intermediary to support managed care claims and prior authorization processing. Proposals are due May 15, 2020, with awards expected to be announced September 11, 2020. Contracts will run from September 11, 2020 until June 30, 2031.

Ohio Releases Medicaid Electronic Data Interchange RFP. Ohio released on March 11, 2020, a request for proposals for an Ohio Medicaid Enterprise System (OMES) Electronic Data Interchange solution for the state Medicaid program, managed care organizations, and providers. Proposals are due April 24, 2020, with awards expected to be announced July 20, 2020. Contracts will run from September 8, 2020 until June 30, 2021 with five, two-year optional renewals.

Tennessee

Lawmaker Halts Medicaid Expansion Bill. *The Tennessean* reported on March 11, 2020, that Tennessee Representative Ron Travis (R-Dayton) stopped short of having the House TennCare Subcommittee vote on a Medicaid expansion bill. Travis, who sponsored the bill with Senator Richard Briggs (R-Knoxville), said that it lacked the votes to pass; however, he expects the bill to be considered later in the year. Read More

National

CMS Issues COVID-19 Guidance to PACE Organizations. On March 17, 2020, the Centers for Medicare & Medicaid Services (CMS) issued guidance to Programs of All-Inclusive Care for the Elderly (PACE) organizations to implement strategies to help prevent the spread of COVID-19. PACE organizations are encouraged to use telehealth to provide patient assessments and reduce PACE center attendance, ensure access to Part D drugs by waiving prior authorization requirements, provide home or mail delivery of drugs, and relax "refill-too-soon" edits. Read More

Hospitals, Providers Seek Additional Support from Congress. *Modern Healthcare* reported on March 17, 2020, that providers are requesting additional support from Congress to provide assistance to frontline healthcare workers. Hospital groups are asking for the suspension of Medicare sequestration cuts, increased funding for child care for healthcare workers to support higher staffing levels, funding for protective equipment, hospital revenue compensation, and delayed cuts to Medicaid disproportionate-share hospital payments. Read More

Hospital Average Medicaid Shortfall Rises Even as Uncompensated Care Costs Fall, Analysis Shows. A *Modern Healthcare* analysis released on March 14, 2020, shows that hospitals' average Medicaid shortfall – i.e., the gap between estimated costs to treat Medicaid patients and reimbursements – rose between 2013 and 2018, even as average uncompensated care costs fell. The analysis comes as hospitals and the federal government are at a standoff over the future of supplemental payments to cover uncompensated care, including disproportionate share hospital (DSH) payments. Read More

House Passes FMAP Increase as Part of COVID-19 Relief Bill. *The National Law Review* reported on March 14, 2020, that the U.S. House passed a 6.2 percent increase in the federal medical assistance percentage (FMAP) as part of an emergency relief bill aimed at combating the impact of COVID-19. Along with increased federal Medicaid match to states, the measure would ensure coverage of COVID-19 diagnostic testing at no cost to Medicaid and CHIP beneficiaries and the uninsured. U.S. territories will also receive an increase to Medicaid allotments for 2020 and 2021. The bill now heads to the Senate. Read More

Medicare to Cover In-Home Telehealth Visits Nationwide in Response to COVID-19. On March 17, 2020, the Centers for Medicare & Medicaid Services (CMS) announced that Medicare will cover in-home telehealth services such as routine visits nationwide in response to COVID-19. Previously, Medicare only paid clinicians for telehealth services in certain circumstances and generally not in the home. Read More

CMS to Relax Regulatory Requirements for Providers, States to Address COVID-19. The Department of Health and Human Services (HHS) announced on March 13, 2020, that it will provide greater flexibility to help healthcare providers and states respond to COVID-19, following the Trump administration's declaration of a national emergency. The Centers for Medicare & Medicaid Services (CMS) will temporarily waive certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) program requirements as authorized by HHS. CMS will also issue Section 1135 waivers to state Medicaid agencies that allow greater flexibilities for states, including allowing for the provision of care in alternative settings and easing provider enrollment requirements in order to promote access to care. Read More

ACA's Impact on Primary Care Hindered by Lack of Financial Support. *Modern Healthcare* reported on March 14, 2020, that the elements of the Affordable Care Act (ACA) designed to elevate primary care to address community health needs have been hindered by a lack a funding. For example, the Prevention and Public Health Fund, which was created by the ACA to allocate $15 billion over 10 years to support primary care efforts, has been constantly underfunded. Instead providers have had to rely on grant funding, philanthropic sources, and self-funding to expand primary care programs in communities. Read More

Trump Administration to Expand COVID-19 Lab Testing. *Modern Healthcare* reported on March 15, 2020, that the Trump Administration will expand testing for COVID-19 to more than 2,000 labs nationwide. Higher-risk individuals will be prioritized for testing, including healthcare workers, first responders, and at-risk seniors. An estimated 1.9 million tests are expected to be processed this week. As of Sunday, nearly 3,000 people are confirmed to have the coronavirus, and 62 people have died. Read More

National Emergency Declaration Gives HHS More Leeway to Address Coronavirus. *Politico* reported on March 13, 2020, that President Trump declared a national emergency over the coronavirus crisis. The declaration will allow the U.S. Health and Human Services (HHS) to waive certain regulations and laws to more quickly deliver testing and care and provides $50 billion in additional funding to assist those affected by the outbreak. Read More

MACPAC Releases March 2020 Report to Congress. The Medicaid and CHIP Payment and Access Commission (MACPAC) released its March 2020 *Report to Congress on Medicaid and CHIP*. The report focused on three issues of interest to Congress: rising hospital uncompensated care at at time when disproportionate-share hospital (DSH) payments are scheduled to decline; state readiness in meeting mandatory quality reporting requirements; and how to improve state-led evaluations of section 1115 waiver demonstrations. Read More

Industry News

Hospitals Bed Shortage Projected Based on COVID-19 Infection Model. *The New York Times* reported on March 17, 2020, that hospitals in nearly all regions of the nation would have to free up or add beds under a scenario in which 40 percent of the population is infected with COVID-19 over 12 months, according to a model from Harvard. The 40 percent scenario is "moderate" in the Harvard model. The worst-case scenario, in which 60 percent of the population is infected, would require an 11-fold increase in intensive care unit capacity, the analysis said. Read More

Prisons, Jails Face Challenges in Preventing Coronavirus Outbreak. *The New York Times* reported on March 17, 2020, that correctional facilities face unique challenges in preventing the coronavirus outbreak, given an environment where social distancing is nearly impossible. State prison systems have suspended visits and barred transfers of inmates between facilities in an effort to curb the spread of the virus. Read More

Mallinckrodt Owes CMS $650 Million in Medicaid Rebates, Court Rules. *Becker's Hospital Review* reported on March 16, 2020, that pharmaceutical company Mallinckrodt has been ordered by the U.S. District Court for the District of Columbia to pay $650 million to the Centers for Medicare & Medicaid Services (CMS) for underpaying Medicaid rebates on its multiple sclerosis drug Acthar. Mallinckrodt says the ruling will also reduce Acthar sales. Read More

Drug Distributors Seek to Settle Opioid Litigation for $19.2 Billion. *The New York Times* reported on March 13, 2020, that drug distributors McKesson, AmerisourceBergen, and Cardinal Health are negotiating a deal to pay $19.2 billion over 18 years to states to settle opioid litigation. The companies would also agree to monitoring and oversight. In exchange, all plaintiffs, including cities and counties, would drop their lawsuits. Funds would go to state attorneys general, who would then be in control of distributing money to cities and counties. Read More

Pharos' Charter Health Care Group Expands Hospice Operations with Two Acquisitions. Pharos Capital Group, LLC, announced on March 13, 2020, that its California-based portfolio company Charter Health Care Group has acquired two hospice service providers. St. Luke's Home Hospice, based in Las Vegas, and Arizona Select Hospice, based in Phoenix, were part of the VeraCare Hospice system. Both management teams will remain with in place. Financial terms were not disclosed. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2020	Louisiana	RFP Rebid Release	1,500,000
January - March 2020	Ohio	RFP Release	2,360,000
February 1, 2020 (DELAYED)	North Carolina - Phase 1 & 2	Implementation	1,500,000
February 2020 (DELAYED)	Texas STAR and CHIP	Awards	3,400,000
April 30, 2020	Indiana Hoosier Care Connect ABD	Awards	90,000
May 5, 2020	Minnesota SNBC - Morrison, Todd, and Wadena Counties	Proposals Due	*NA*
June 16, 2020	Minnesota SNBC - Morrison, Todd, and Wadena Counties	Awards	*NA*
July 1, 2020	Minnesota SNBC - Morrison, Todd, and Wadena Counties	Implementation	*NA*
July 1, 2020	Hawaii	Implementation	340,000
July 1, 2020	West Virginia Mountain Health Trust	Implementation	400,000
September 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR Kids - Dallas Service Area	Implementation	21,000
October 1, 2020	Washington DC	Implementation	224,000
December 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
2021	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	RFP Release	1,640,000
2021	California GMC - Sacramento, San Diego	RFP Release	1,091,000
2021	California Imperial	RFP Release	75,000
2021	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	RFP Release	286,000
2021	California San Benito	RFP Release	7,600
January 2021	Nevada	RFP Release	465,000
January 1, 2021	Kentucky Rebid	Implementation	1,200,000
January 1, 2021	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2021	Pennsylvania HealthChoices Physical Health	Implementation	2,260,000
April 1, 2021	Indiana Hoosier Care Connect ABD	Implementation	90,000
September 1, 2021	Texas STAR Health (Foster Care)	Operational Start Date	34,000
January 2024	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare	Implementation	1,640,000
January 2024	California GMC - Sacramento, San Diego	Implementation	1,091,000
January 2024	California Imperial	Implementation	75,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	286,000
January 2024	California San Benito	Implementation	7,600

HMA WELCOMES

Katie Clay – Senior Consultant

A skilled program developer and health home expert, Katie Clay is an exceptional communicator, problem solver and leader with experience implementing and leading healthcare programs and services.

Katie has focused her career on care management and care coordination as well as all aspects of the Health Home program. Before joining HMA, she served as director of Home Health Program for Hudson River Healthcare (HRHCare) where she oversaw the largest New York State Medicaid Health Home Care Management program across 10 counties.

Her work included creating and maintaining policies and standards, leading acquisition and integration efforts, managing staff and staffing needs, and serving as an advocate and liaison to improve policies, payment rates, and address change.

Katie has strong management experience including team leadership, staff mentoring and serving as a strategic planning expert. She served HRHCare in a variety of other capacities including program manager and Community HealthCorp/Americorps volunteer.

Her work as an Americorps volunteer included helping Spanish-speaking community members navigate local resources, starting a community health workers program to survey local businesses, teaching an English as a second language class and leading a Spanish-speaking women's group.

She is dedicated to providing better healthcare for all and earned a Bachelor of Science degree in biology and a Bachelor of Arts degree in Spanish from Gettysburg College as well as completed a study abroad program in Panama where she focused on development, conservation, and research. She remains connected to Panama as the president of Few for Change, a Panama-based non-profit.

Elizabeth Lopez – Senior Associate

With a deep understanding of the financial and economic side of public healthcare, Elizabeth Lopez provides HMA with expertise in healthcare policy, financing, statistical analysis and payment methodology.

She has worked as an economist examining payment rates, researching data sources, completing statistical analysis, project evaluations, and data visualizations using Stata, SQL and Tableau.

Before joining HMA, Elizabeth worked for the Colorado Department of Healthcare Policy and Financing for more than 12 years. She served as an analyst on several state-wide projects focused on payment rates, reimbursement evaluation, program policies and implementation for participating providers including hospitals, Federally Qualified Health Centers and Rural Health Clinics.

She taught economics, statistics and computing courses before earning a master's degree in economics from the University of Colorado at Denver and Health Science Center. She completed her bachelor's degree in economics and statistics from Carabobo University in Venezuela.

Susan Seling – Senior Consultant

Susan Seling has been working for more than 25 years to build the capacity and effectiveness of health and human services organizations and systems. During her career, she has led critical initiatives in the public and private sectors that have resulted in dynamic technology, human resources, planning, and service delivery approaches.

Her work has included serving Montgomery County, Maryland as chief of human capital management and organizations development where she oversaw labor relations, strategic recruitment and retention, leadership and organizational development and organizational climate change. Susan also served the county as director of the Office of Planning and Accountability.

With a keen eye to assess risk and respond to the needs of the organization, Susan has a strategic and thoughtful approach to human capital management, project risk, stakeholder engagement and program integration and development.

Susan served as director of human capital management and staff development for the Graduate School, a training and education provider for adult learners where she successfully transformed the human resources structure. In addition, she has prior experience in non-profit leadership in the areas of child advocacy and victim's services as well as extensive state and local human services delivery leadership.

Susan has a master's degree in community planning from the University of Maryland and a Change Management Certificate from Cornell University. She is committed to continual internal growth and development and has pursued training and certifications in critical areas supporting the quality of health and human services systems.

HMA News

New this week on HMA Information Services (HMAIS):

Medicaid Data

- California Dual Demo Enrollment is Down 2.1%, Jan-20 Data
- California Medicaid Managed Care Enrollment is Down 1.0%, Jan-20 Data
- Colorado RAE Enrollment is Up 6.9%, Feb-20 Data
- Georgia Medicaid Management Care Enrollment is Flat, Mar-20 Data
- Indiana Medicaid Managed Care Enrollment Is Up 1.5%, Feb-20 Data
- Iowa Medicaid Managed Care Enrollment is Flat, Mar-20 Data
- Kentucky Medicaid Managed Care Enrollment is Up 0.7%, Mar-20 Data
- Ohio Dual Demo Enrollment is Up 4.0%, Mar-20 Data
- Oregon Medicaid Managed Care Enrollment is Up 1.1%, Feb-20 Data
- Rhode Island Dual Demo Enrollment is Down 5.8%, Mar-20 Data
- Tennessee Medicaid Managed Care Enrollment is Up 0.6%, Feb-20 Data
- Tennessee Medicaid Managed Care Enrollment is Up 0.6%, Jan-20 Data
- Utah Medicaid Managed Care Enrollment is Up 11.0%, Mar-20 Data
- Washington Medicaid Managed Care Enrollment is Flat, Feb-20 Data
- Wisconsin Medicaid Managed Care Enrollment is Flat, Jan-20 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Arkansas External Quality Review Organization RFP, Jan-20
- Arkansas Provider Enrollment RFI, Feb-20
- Delaware Medicaid MCO Contract, 2018
- Hawaii QUEST Integration Section 1115 CMS Quarterly Report, 1Q20
- New Jersey Fee-For-Service Transition Consultant REVISED RFQ and Related Documents, 2019-20
- Nevada Cost-Based Rate Study on Services Under the HCBS Waiver RFP, Mar-20
- Ohio Medicaid Enterprise System Electronic Data Interchange RFP, Mar-20
- Virginia Medicaid Developing Telemedicine Curriculum for SUD/OUD Treatment Delivery RFP, Mar-20

Medicaid Program Reports, Data and Updates:

- CMS FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19), Mar-20
- MACPAC Reports to Congress on Medicaid and CHIP, 2017-20
- Proposed Families First Coronavirus Response Act House Bill, Mar-20
- Alaska MMIS Solicitation Consultant RFP, Mar-20
- California Managed Care Advisory Group Meeting Materials, Mar-20
- Colorado Children's Health Plan Plus Caseload by County, Feb-20
- Florida Section 1135 Waiver Approval, Mar-20
- North Dakota Medicaid Provider Enrollment NOI, Mar-20
- New Hampshire Medical Care Advisory Committee Meeting Materials, Feb-20

- New Mexico Random Moment Sampling for Medicaid Administrative Claiming RFP, Mar-20
- New York DOH Value-Based Payment Quality Measure Sets, 2020
- New York Medicaid Redesign Team II Meeting Presentations, Mar-20
- Oklahoma Medical Advisory Meeting Materials, Mar-20
- Rhode Island Medical Care Advisory Committee Meeting Materials, Mar-20
- South Carolina Medical Care Advisory Committee Meeting Materials, Mar-20
- Tennessee Medicaid Managed Care Enrollment by Age, Gender, County, 2015-19, Feb-20
- Vermont Medicaid and Exchange Advisory Board Meeting Materials, Feb-20

A subscription to HMA Information Services puts a world of Medicaid information at your fingertips, dramatically simplifying market research for strategic planning in healthcare services. An HMAIS subscription includes:

- State-by-state overviews and analysis of latest data for enrollment, market share, financial performance, utilization metrics and RFPs
- Downloadable ready-to-use charts and graphs
- Excel data packages
- RFP calendar

If you're interested in becoming an HMAIS subscriber, contact Carl Mercurio at cmercurio@healthmanagement.com.

HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With 23 offices and over 200 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.